STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	09/13/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROWNPOINTE OF ANDERSON	2727 CROWNPOINTE CIRCLE ANDERSON, IN46012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R0000	This visit was for the investigation of Complaint #IN00095111. Complaint #IN00095111 - Substantiated. State Residential deficiencies related to the allegations are cited at R52, R214, and R349. Unrelated State Residential deficiencies are cited. Survey dates: September 12 and 13, 2011 Facility number: 012129 Provider number: 012129 AIM number: N/A Survey Team: Ginger McNamee, RN, TC Betty Retherford, RN (9/12/11) Census bed type: Residential: 40 Total: 40 Census payor type: Medicaid: 8 Other: 32 Total: 40 Sample: 4	R0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	09/13/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROWNPOINTE OF ANDERSON	2727 CROWNPOINTE CIRCLE ANDERSON, IN46012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	These State Residential findings are cited in accordance with 410 IAC 16.2-5. Quality review completed 9/15/11 Cathy Emswiller RN			
R0052	(v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on record review, observation, and interview, the facility failed to ensure each resident was free from neglect related to a lack of evaluation and monitoring following an elopement from the facility and an expression of suicidal ideations with the potential for self harm for 1 of 1 resident reviewed for protection from self harm in sample of 4. (Resident #B) Findings include: The clinical record for Resident #B was reviewed on 9/12/11 at 9:35 a.m. Diagnoses for Resident #B included, but	R0052	Current elopement Risk - Resident B was evaluated by a mental health clinician who recommended that the resident return to the assisted living environment with couseling for anger reaction. Although it was believed by the clinician the residents's exit from the facility was due to anger, and lacking suicidal intent, the facility continues to consider Resident B at risk for elopement. The resident has not exhibited exit-seeking behavior nor voiced a desire to leave the facility: however, the facility continues the every 30 minute checks to confirm whereabouts of the resident until deem no longer appropriate by mental health	09/30/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	09/13/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROWNPOINTE OF ANDERSON	2727 CROWNPOINTE CIRCLE ANDERSON, IN46012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	were not limited to, dementia, congestive heart failure,diabetes mellitus type 2, Parkinson's disease, and depression. The clinical record indicated Resident #B had a current order for Pristiq (an antidepressant medication) 60 milligrams one tablet daily for depression. An Elopement Risk Assessment, dated 8/11/11, indicated Resident #B was assessed to be an elopement risk because she was mobile and had dementia. The form indicated the resident met the criteria for an elopement risk but at no time had "tried to leave the facility or verbalized a desire to leave the facility thus has adjusted well to living at the facility and it is felt that the resident is not at risk and will remain at the facility". The form indicated the decision to not seek placement within a secured facility had been addressed with the resident family/responsible party and all concurred with the resident remaining at the facility. During an interview on 9/12/11 at 9:40 a.m., the Director of Nursing indicated the facility was not a "locked" facility. She indicated all of the exterior doors were alarmed, but the alarm was not on during the daytime hours. She indicated the door alarms were turned on at 7:00 p.m. and remained on during the night. She		clinician. An appointment to start counseling has been scheduled for Resident B on 10/20/11 with Dr Melissa Zehr at the Anderson Center. The family remains in agreement with this plan. Should Resident B begin to exhibit exit-seeking behavior and /or voice suicidal ideations, the physican and family shall be consulted in regard to alternate placement.Interventions - The resident continues on every 30 minute checks to confirm whereabouts and to assess demeaner in an effort to identify exit -seeking behavior and/or suicidal ideations at the earliest sign of the same. The mental health clinician and family have deemed the assisted living environment to remain appropriate, thus the facility will continue current interventions unless the Resident's behavior indicates greater supervision is needed. As a means to ensure ongoing compliance with ensuring each resident is free from neglect related to a lack of evaluation and monitoring following elopement from the facility and/or expressions of suicidal ideations, staff has been addressed in regard to immediately reporting to administrative staff any exit seeking behavior, elopement and /or verbal expressions of suicidal ideations made by any resident. Administrative staff shall be responsible to monitor for compliance ongoing through	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	09/13/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROWNPOINTE OF ANDERSON	2727 CROWNPOINTE CIRCLE ANDERSON, IN46012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	indicated any resident could exit the building during daytime hours and no alarm would sound. A nursing note, dated 8/24/11 at 11:20 a.m., indicated the following: "At 9:45 a.m., resident was found out of building sitting on grass. States she was headed to highway [Highway 32 visible from the entrance to the facility] "to throw herself in front of a car." States she has things missing in room. [Name of home health care agency] PT [physical therapist] present for therapy. Resident ambulated back to building with therapist. Call placed to son. At 10:30 a.m., [name of home health care agency] nurse was in and was instructed by her director to call 911. [Name of home health care agency] nurse called son and doctor's office. [Name of medical doctor] office returned call at 11:20 a.m. to send resident for eval [evaluation]...." The next nursing note entry, dated 8/25/11 at 7:30 a.m., indicated the following: "Resident returned yesterday evening, time unknown. Up this am. Pleasant and visiting with other residents. Telling everyone about her trip to ER [emergency room]."		review of staff reports daily on scheduled days of work, as well as review of shift to shift reporting in an effort to identify any concerns with aforementioned behaviors and to affirm that should such behavior have been observed, the same has been reported to administrative staff for immediate intervention, including evaluation and monitoring. Should non-compliance be identified, immediate corrective action shall be taken.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	09/13/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROWNPOINTE OF ANDERSON	2727 CROWNPOINTE CIRCLE ANDERSON, IN46012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	This was the last nursing note entry at time of review on 9/12/11 at 9:35 a.m. The clinical record lacked: any emergency room evaluation and or possible new orders resulting from the ER visit; any reassessment of the resident upon readmission to the facility related to being an elopement and/or suicide risk, and any facility interventions put into place to ensure the resident's safety following her expression of suicide ideations. During an interview with the Director of Nursing (DoN) on 9/12/11 at 10:55 a.m., she indicated the facility did not send a transfer form with the resident to the hospital. She indicated they usually send a "face sheet" and copy of current doctor's orders. She indicated the facility usually called the ER when a resident was being sent out, but could not remember if she called the ER regarding Resident #B's transfer or if the home health care agency nurse had called. She indicated she could not say for sure if the ER was aware of the resident's suicidal expressions, but she knew the ambulance staff was aware. She indicated the facility did not receive a copy of the emergency room discharge information. She stated this information is given to the families when they take residents to the ER and the facility did not get this information unless the family tells them of a new medication order and/or			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	09/13/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROWNPOINTE OF ANDERSON	2727 CROWNPOINTE CIRCLE ANDERSON, IN46012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	other changes. During an interview with the Administrator Designee and DoN on 9/12/11 at 11:10 a.m., they indicated the home health care agency staff had found the resident in the grass around to the side of the building and had summoned facility staff to the area. The resident had walked down the walkway with her walker around to the side of the building. They indicated they are not sure what time the resident had left the building, but had been in the facility for breakfast that morning. They indicated the resident continued to sit out on the front porch area furniture since she had returned from the ER. The DoN indicated the resident had not been re-evaluated upon her return to the facility after her elopement and no interventions had been put into place to monitor her. She indicated she did not know what time the resident had returned to the facility on 8/24/11 or if she had any new orders at the time of her return. During an interview on 9/12/11 at 1:20 p.m., the DoN indicated she had obtained a copy of the emergency room discharge orders from the hospital. She indicated two new medication orders had been written for the resident related to the ER visit. The new orders were for: Risperdal (an antipsychotic medication) 0.5			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	09/13/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROWNPOINTE OF ANDERSON	2727 CROWNPOINTE CIRCLE ANDERSON, IN46012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	milligrams once tablet once daily (15 tabs ordered) and Ativan (an antianxiety medication) 0.5 milligrams three times daily as needed for anxiety (15 tabs ordered). The discharge instructions also indicated the resident was to have a follow-up appointment with her personal physician in 7 days. The DoN indicated she was not aware of these orders prior to 9/12/11. The DoN indicated she had called the resident's son and he had not filled the Risperdal order and had "refused" it. She indicated she did not know if the resident's son had filled the as needed antianxiety medication or not. She indicated the facility was now in the process of obtaining orders for a psychiatric referral for the resident to follow-up on her elopement and suicidal ideations made on 8/24/11. This indicated a time period of 19 days from the time the resident eloped from the facility and expressed suicidal ideations and the facility became aware of emergency room discharge information and/or addressed the resident's need for re-evaluation and assessment. During an observation on 9/12/11 at 1:20 p.m., Resident #B was up in the front lobby sitting on a couch near the front door of the building. Her walker was next to her by the couch.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	09/13/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROWNPOINTE OF ANDERSON	2727 CROWNPOINTE CIRCLE ANDERSON, IN46012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	This State Residential tag relates to Complaint #IN00095111.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	09/13/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROWNPOINTE OF ANDERSON	2727 CROWNPOINTE CIRCLE ANDERSON, IN46012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R0090	(g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B)poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and (B) dates and hours worked during the past twelve (12) months. (5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	09/13/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROWNPOINTE OF ANDERSON	2727 CROWNPOINTE CIRCLE ANDERSON, IN46012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	notice posted of their availability. (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request Based on record review and interview, the facility failed to notify the Indiana State Department of Health (ISDH) of an unusual occurrence within 24 hours of becoming aware of the occurrence for 1 of 1 resident reviewed who had eloped from the facility and expressed suicidal ideations in a sample of 4. (Resident #B) Findings include: The clinical record for Resident #B was reviewed on 9/12/11 at 9:35 a.m. Diagnoses for Resident #B included, but were not limited to, dementia, congestive heart failure,diabetes mellitus type 2, Parkinson's disease, and depression. An Elopement Risk Assessment, dated 8/11/11, indicated Resident #B was assessed to be an elopement risk because she was mobile and had dementia. The form indicated the resident met the criteria for an elopement risk but at no time had "tried to leave the facility or verbalized a desire to leave the facility thus has adjusted well to living at the facility and it is felt that the resident is not	R0090	I. In regards to resident # B as a result of this incident the Administrator, Designee and Health and Services Director have reveiwed the facility policy on Unsual Occurences, have been educated as to the reportable unsual occurence guidlines and timely reporting in accordance with ISDH guidelines. II. All residents have the potential to be affected by the deficient practice. The Administrator, Designee and Health and Services Director have reveiwed the policy on Unsual Occurences , have been educated as to the reportable unusal occurence guidelines and timely reporting for all residents. The Accident/Incident Report Form has been up dated to include reportable occurence and date filed. III. As a means of ongoing compliance with reporting unsual occurences all staff will be educated on the Unusal Occurences Policy, what occurences are reportable, proper immediate notification and forwarding of incident reports/records to administrative staff for timely reveiw and response including reporting to ISDH.IV. As a means	09/30/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	09/13/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROWNPOINTE OF ANDERSON	2727 CROWNPOINTE CIRCLE ANDERSON, IN46012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	at risk and will remain at the facility". The form indicated the decision to not seek placement within a secured facility had been addressed with the resident family/responsible party and all concurred with the resident remaining at the facility. During an interview on 9/12/11 at 9:40 a.m., the Director of Nursing indicated the facility was not a "locked" facility. She indicated all of the exterior doors were alarmed, but the alarm was not on during the daytime hours. She indicated the door alarms were turned on at 7:00 p.m. and remained on during the night. She indicated any resident could exit the building during daytime hours and no alarm would sound. A nursing note, dated 8/24/11 at 11:20 a.m., indicated the following: "At 9:45 a.m., resident was found out of building sitting on grass. States she was headed to highway [Highway 32 visible from the entrance to the facility] "to throw herself in front of a car." States she has things missing in room. [Name of home health care agency] PT [physical therapist] present for therapy. Resident ambulated back to building with therapist. Call placed to son. At 10:30 a.m., [name of home health care agency] nurse was in and was instructed by her director to call		to ensure ongoing compliance wth notifcation of the ISDH of an unusual occurrence within 24 hours of an unusual occurrence within 24 hours of becoming aware of the occurrence, administrative staff shall be responsible to report to the corporate structure on a weekly basis continued review of incidents occurring within the facility and comparison to Reporting Guidance to confirm necessity of reporting, as applcable, and to confirm continued compliance therewith.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	09/13/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROWNPOINTE OF ANDERSON	2727 CROWNPOINTE CIRCLE ANDERSON, IN46012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	911. [Name of home health care agency] nurse called son and doctor's office. [Name of medical doctor] office returned call at 11:20 a.m. to send resident for eval [evaluation]...." During an interview with the Administrator Designee and DoN on 9/12/11 at 11:10 a.m., they indicated the home health care agency staff had found the resident in the grass around to the side of the building had summoned facility staff to the area. The resident had walked down the walkway with her walker around to the side of the building. They indicated they were not sure what time the resident had left the building, but had been in the facility for breakfast that morning. The Administrator Designee indicated the above noted resident elopement with expressions of suicidal ideations had not been reported to the ISDH. Review of the current facility policy, dated 12-3, provided by the Administrator Designee on 9/12/11 at 10:40 a.m., titled "Unusual Occurrences", included, but was not limited to, the following: "Policy: This facility shall insure that the division is immediately informed by telephone or			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	09/13/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROWNPOINTE OF ANDERSON	2727 CROWNPOINTE CIRCLE ANDERSON, IN46012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	fax, within twenty-four (24) hours, of becoming aware of an unusual occurrence that directly threatens the welfare, safety or health of the resident or residents, ..."			
R0214	(a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident. Based on record review and interview, the facility failed to ensure a resident was re-evaluated following a known substantial change in the resident's condition for 1 of 1 resident who eloped from the building and expressed suicidal ideations in sample of 4. (Resident #B) Findings include: The clinical record for Resident #B was reviewed on 9/12/11 at 9:35 a.m. Diagnoses for Resident #B included, but were not limited to, dementia, congestive heart failure, diabetes mellitus type 2, Parkinson's disease, and depression.	R0214	In regards to Resident B as a result of this incident the resident was re-evaluated by the Health and Services Director on 9/14/11 and was put on 30 minute monitoring checks for elopement risk. Resident B was also evalutated by a mental health clinician who recommended that the resident return to the assisted living environment with counseling for anger reaction. Although it was believed by the clinician the resident's exit from the facility was due to anger, and lacking suicidal intent, the facility continues to consider Resident B at risk for elopement. The resident had not exhibited exit-seeking behavior nor voiced a desire to leave the facility; however, the facility continues the	09/30/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	09/13/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROWNPOINTE OF ANDERSON	2727 CROWNPOINTE CIRCLE ANDERSON, IN46012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	An Elopement Risk Assessment, dated 8/11/11, indicated Resident #B was assessed to be an elopement risk because she was mobile and had dementia. The form indicated the resident met the criteria for an elopement risk but at no time had "tried to leave the facility or verbalized a desire to leave the facility thus has adjusted well to living at the facility and it is felt that the resident is not at risk and will remain at the facility". The form indicated the decision to not seek placement within a secured facility had been addressed with the resident family/responsible party and all concurred with the resident remaining at the facility. During an interview on 9/12/11 at 9:40 a.m., the Director of Nursing indicated the facility was not a "locked" facility. She indicated all of the exterior doors were alarmed, but the alarm was not on during the daytime hours. She indicated the door alarms were turned on at 7:00 p.m. and remained on during the night. She indicated any resident could exit the building during daytime hours and no alarm would sound. A nursing note, dated 8/24/11 at 11:20 a.m., indicated the following: "At 9:45 a.m., resident was found out of building sitting on grass. States she was		every 30 minute checks to confirm the whereabouts of the Resident until deemed no longer appropriate by the mental health clinician. All residents have the potential to be affected by this deficient practice. Residents will be assessed on admission and every 3 months. Any substantial change or event in residents health or behavior will beevaluated immediately and appropriate measures taken.As a means to ensure ongoing compliance in ensuring a resident is re-evaluated following a known substantial change in the resident's condition and/or upon return from hospitalization. Administrative staff shall be responisble to review staff reports daily on schedule days of work, as well as review shift-to-shift reporting in an effort to identify any change in condition and to affirm that the same, if observed, was followed by a re-evaluation of current care and to ensure that the service plan remains appropriate to the needs of the resident. Further, staff shall be responsible to inquire of the resident and family of any revision in care following hospitalization, as well as review any accompanying paperwork/reports in an effort to ensure any recommendations/care needs are met. Administrative staff shall be responsible to audit for appropriate resident re-evaluation following a known substantial	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	09/13/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROWNPOINTE OF ANDERSON	2727 CROWNPOINTE CIRCLE ANDERSON, IN46012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	headed to highway [Highway 32 visible from the entrance to the facility] "to throw herself in front of a car." States she has things missing in room. [Name of home health care agency] PT [physical therapist] present for therapy. Resident ambulated back to building with therapist. Call placed to son. At 10:30 a.m., [name of home health care agency] nurse was in and was instructed by her director to call 911. [Name of home health care agency] nurse called son and doctor's office. [Name of medical doctor] office returned call at 11:20 a.m. to send resident for eval [evaluation]...." The next nursing note entry, dated 8/25/11 at 7:30 a.m., indicated the following: "Resident returned yesterday evening, time unknown. Up this am. Pleasant and visiting with other residents. Telling everyone about her trip to ER [emergency room]." This was the last nursing note entry at the time of review on 9/12/11 at 9:35 a.m. The clinical record lacked any re-evaluation of the resident since her readmission to the facility related to her having eloped from the facility and expression of a suicidal ideation. During an interview with the Director of		change in resident's condition and/or return from hospital treatment to ensure complance therewith. Should non-compliance be identified immedate corrective action shall be taken.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	09/13/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROWNPOINTE OF ANDERSON	2727 CROWNPOINTE CIRCLE ANDERSON, IN46012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Nursing on 9/12/11 at 11:10 a.m., she indicated the resident had not been re-evaluated upon her return to the facility from the ER after her elopement and no interventions had been put into place to monitor her. This State Residential tag relates to Complaint #IN00095111.			
R0349	(a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on record review and interview, the facility failed to ensure each resident's clinical record was complete and accurately documented for 1 of 1 resident reviewed for information related to an emergency room visit in a sample of 4 (Resident #B) and failed to ensure 1 of 1 resident's clinical record reviewed for falls had complete documentation of the falls in a sample of 4. (Resident #E)	R0349	Resident # B was re-evaluated on 9/14/11.Assessments/evaluations and monitoring logs have beendocumented in applicable clinical record. Resident # E was discharged to a Skilled Facility on 09/02/11 prior to survey.In an effort to identify any other residents who may be affected, current clinical records of all residents will be reviewed to ensure record of any	10/04/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	09/13/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROWNPOINTE OF ANDERSON	2727 CROWNPOINTE CIRCLE ANDERSON, IN46012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Findings include: 1. The clinical record for Resident #B was reviewed on 9/12/11 at 9:35 a.m. Diagnoses for Resident #B included, but were not limited to, dementia, congestive heart failure,diabetes mellitus type 2, Parkinson's disease, and depression. A nursing note, dated 8/24/11 at 11:20 a.m., indicated the following: "At 9:45 a.m., resident was found out of building sitting on grass. States she was headed to highway [Highway 32 visible from the entrance to the facility] "to throw herself in front of a car." States she has things missing in room. [Name of home health care agency] PT [physical therapist] present for therapy. Resident ambulated back to building with therapist. Call placed to son. At 10:30 a.m., [name of home health care agency] nurse was in and was instructed by her director to call 911. [Name of home health care agency] nurse called son and doctor's office. [Name of medical doctor] office returned call at 11:20 a.m. to send resident for eval [evaluation]...." The next nursing note entry, dated 8/25/11 at 7:30 a.m., indicated the following:		applicable documentation and/or evaluation has been recorded in the residents clinical record. As a means to ensure ongoing compliance in ensuring each resident's clinical record is complete and accurately documented, staff has been addressed relative to the need to document resident status apon return from any treatment received and to assess any documentation accompanying a resident from such a visit to ensure necessary care/treatment is sought/administered and/or service plan is revised as warranted. Adminstrative staff shall monitor for compliance on scheduled days of work. Should non-compliance be identified, immedate corrective action shall be taken.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	09/13/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROWNPOINTE OF ANDERSON	2727 CROWNPOINTE CIRCLE ANDERSON, IN46012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

"Resident returned yesterday evening, time unknown. Up this am. Pleasant and visiting with other residents. Telling everyone about her trip to ER [emergency room]."

This was the last nursing note entry at time of review on 9/12/11 at 9:35 a.m. The clinical record lacked any return information from the emergency room visit related to possible new orders and/or follow-up care needed.

During an interview with the Director of Nursing (DoN) on 9/12/11 at 10:55 a.m., additional information was requested related to the lack of emergency room discharge information noted above. She indicated the facility did not receive a copy of the emergency room discharge information for Resident #B. She stated this information is given to the families when they take residents to the ER and the facility does not get this information unless the family tells them of a new medication order and/or follow-up care needed.

During an interview on 9/12/11 at 1:20 p.m., the DoN indicated she had obtained a copy of the emergency room discharge orders. She indicated two new medication orders had been written for the resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	09/13/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROWNPOINTE OF ANDERSON	2727 CROWNPOINTE CIRCLE ANDERSON, IN46012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	related to the ER visit. The new orders were for: Risperdal (an antipsychotic medication) 0.5 milligrams once tablet once daily (15 tabs ordered) and Ativan (an antianxiety medication) 0.5 milligrams three times daily as needed for anxiety (15 tabs ordered). The discharge instructions also indicated the resident was to have a follow-up appointment with her personal physician in 7 days. The DoN indicated she was not aware of these orders prior to 9/12/11. 2. Resident #E's clinical record was reviewed on 9/13/11 at 9:20 a.m. The resident's diagnoses included, but were not limited to, hypertension, angina, degenerative joint disease, and osteoporosis. The resident had a 4/24/11, Service Plan. The Service Plan indicated the resident was alert, orientated, and had some difficulty with decisions in new situations. The Service Plan indicated the resident was independent with toileting and ambulation. Review of a 8/10/11, 2:00 p.m., Progress			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	09/13/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROWNPOINTE OF ANDERSON	2727 CROWNPOINTE CIRCLE ANDERSON, IN46012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Note written by the Director of Nursing [DoN] indicated the resident had several falls at night in the past few weeks on 8/2/11, 8/3/11, and 8/10/11. The clinical record lacked any documentation related to the resident having any falls on 8/2/11 and 8/3/11. During an interview with the DoN on 9/13/11 at 9:00 a.m., she indicated she is the only nurse on staff and the only one permitted to document in the clinical record. She indicated CNA's leave a communication for her about resident falls and she documents them when she returns to work. This State Residential tag relates to Complaint #IN00095111.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	09/13/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROWNPOINTE OF ANDERSON	2727 CROWNPOINTE CIRCLE ANDERSON, IN46012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R0354	(g) A transfer form shall include the following: (1) Identification data. (2) Name of the transferring institution. (3) Name of the receiving institution and date of transfer. (4) Resident ' s personal property when transferred to an acute care facility. (5) Nurses ' notes relating to the resident ' s: (A) functional abilities and physical limitations; (B) nursing care; (C) medications; (D) treatment; and (E) current diet and condition on transfer. (6) Diagnosis. (7) Date of chest x-ray and skin test for tuberculosis.			
	Based on record review and interview, the facility failed to ensure all required transfer information was provided for 1 of 1 resident reviewed who was sent to the hospital following an elopement and expression of suicidal ideations in a sample of 4. (Resident #B) Findings include: The clinical record for Resident #B was reviewed on 9/12/11 at 9:35 a.m. Diagnoses for Resident #B included, but were not limited to, dementia, congestive heart failure,diabetes mellitus type 2, Parkinson's disease, and depression. A nursing note, dated 8/24/11 at 11:20 a.m., indicated the following:	R0354	In regards to resident # B, as a result of this incident a transfer form has been developed with required transfer information and implemented for resident transfers to the hospital.All residents have the potential to be affected by the deficient practice, a transfer form has been developed with the required information and implemented for all resident transfers to the hospital.As a means of ongoing compliance all staff will be inserviced on the use of the transfer form and what pertient information is required to be on the transfer form. As a means to ensure ongoing compliance in ensuring all required transfer information is provided. adminstrative staff shall reveiw for correct completion of the transfer form on scheduled days of work to ensure all pertient information is included to ensure through	09/30/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	09/13/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROWNPOINTE OF ANDERSON	2727 CROWNPOINTE CIRCLE ANDERSON, IN46012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	"At 9:45 a.m., resident was found out of building sitting on grass. States she was headed to highway [Highway 32 visible from the entrance to the facility] "to throw herself in front of a car." States she has things missing in room. [Name of home health care agency] PT [physical therapist] present for therapy. Resident ambulated back to building with therapist. Call placed to son. At 10:30 a.m., [name of home health care agency] nurse was in and was instructed by her director to call 911. [Name of home health care agency] nurse called son and doctor's office. [Name of medical doctor] office returned call at 11:20 a.m. to send resident for eval [evaluation]...." The clinical record lacked any information related to transfer form information sent with the resident to the emergency room. During an interview with the Director of Nursing (DoN) on 9/12/11 at 10:55 a.m., she indicated the facility did not send a transfer form with the resident to the hospital. She indicated they usually send a "face sheet" and copy of current doctor's orders. She indicated the staff usually called the ER when a resident was being sent out, but could not remember if she called the ER regarding Resident #B's transfer or if the home health care agency		assessment and treatment of the resident's need(s). Should transfer occur while adminstrative staff is off-site, upon return or next tour of duty, adminstrative staff shall audit for correct communication of transfer information. Should non-compliance be idenitified, immeditate corrective action shall be taken.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	09/13/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROWNPOINTE OF ANDERSON	2727 CROWNPOINTE CIRCLE ANDERSON, IN46012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	nurse had called. She indicated she could not say for sure if the ER was aware of the resident's expression of suicidal ideations, but she knew the ambulance staff was aware. During a review of the "face sheet" and physicians orders on 9/12/11 at 11:00 a.m., the following required transfer form information was not included in the information contained on those two records sent with the resident to the hospital: Name of receiving institution and date of transfer Resident's personal property when transferred to an acute care facility Nurses's notes relating to the resident's functional abilities, physical limitations, and nursing care Date of chest x-ray and skin test for tuberculosis This required information would not have been included on the two forms sent with the resident. These forms did not include any section to be filled in documenting why the resident was being sent to the hospital.			